CONTRACT HEALTH SERVICES

Indian Health Service

Clinical Services	2000 Actual	2001 Appropriation	2002 Estimate	2002 Est. +/- 2000 Actual	2002 Est. +/- 2001 Approp.
Contract Health Services					
Budget Authority	$406,756,000	$445,773,000	$445,776,000	+$39,020,000	+$3,000
Gen. Med & Surg. Hospitalization: ADPL	248	252	248	0	-4
Ambulatory Care: Outpatient Visits	490,700	541,600	507,305	+16,605,000	-34,295
Patient & Escort Travel: One Way Trips	35,900	39,600	37,007	+1,107	-2,593
Dental Services	60,600	66,900	61,678	+1,078	-5,222

PURPOSE AND METHOD OF OPERATION

Program Mission and Responsibilities

The IHS Contract Health Services (CHS) program supplements the health care resources available to eligible American Indian and Alaska Native (AI/AN) people with the purchase of medical care and services that are not available within the IHS direct care system. The IHS purchases both basic and specialty health care services from local and community health care providers, including hospital care, physician services, outpatient care, laboratory, dental, radiology, pharmacy, and transportation services such as ground and air ambulance. The CHS program also supports the provision of care in IHS and tribally operated facilities, such as specialty clinics, e.g., orthopedics and neurology, and referrals to specialists for diagnostic services.

The CHS program is administered through 12 IHS Area Offices that consist of 66 IHS-operated Service Units and 84 tribally operated health programs. Although the IHS facilities include two major medical centers, and one tribally medical center most of the IHS and tribally operated facilities are small rural community hospitals and health centers with basic primary care services. In addition, not all tribes have access to IHS or tribally operated facilities or have limited access. Therefore, those Areas with few or no direct care facilities have a higher reliance on the CHS program to provide the needed health care.

The CHS budget includes a Catastrophic Health Emergency Fund (CHEF) of $15,000,000 in FY 2001 which was increased by $3 Million from the previous year and is intended to protect local CHS operating budgets from overwhelming expenditures for certain high cost cases. To access the

FY 2000 $12 million CHEF program, a threshold of $20,100 established by the annual change in the consumer price index as mandated by congressional legislation must be first met. Once the threshold was met, the $12 million CHEF budget for FY 2000 provided funds for more than 800 high cost cases in amounts ranging from $1,000 to $600,000 per case. The FY 2002 Budget continues CHEF at $15,000,000.

Best Practices/Industry Benchmarks

Because of high patient demand, the IHS relies on strict adherence to specific CHS guidelines to ensure that the most effective use of CHS dollars is attained. As much as possible, the IHS pursues negotiated rate agreements with private health care providers to obtain health care at reduced rates, including managed care arrangements. In addition to the CHS requirement for eligibility, the IHS utilizes a medical priority system and is considered to be the payer of last resort. This means that all alternate resources that a patient is eligible for must be first exhausted, before the IHS can pay. Tribal contractors generally provide services under the same CHS regulations as the IHS.

In addition, the IHS fiscal intermediary (FI) contract with Blue Cross/Blue Shield of New Mexico provides a mechanism of payment to services in the private sector. The FI ensures that payments are made accurately and timely according to contractual requirements where applicable, and maintains a centralized medical and dental claims reimbursement system. The FI process functions within the IHS payment policy and meets the standards of the medical industry. In addition to providing payments to vendors, the FI provides program support services that collects, compiles, organizes workload, and financial data, and generates statistical reports to the IHS that support the administration of CHS programs.

Findings Influencing FY 2002 Request

Increased costs for professional care services:

- According to the Bureau of Labor Statistics, the Consumer Price Index for Medical Care increased 3.6 percent between 1998 and 1999, whereas for professional care services the IHS FI reported an increased cost of 5.83 percent for 1999.

ACCOMPLISHMENTS

In FY 2001, the CHS program received a significant increase of $40 Million. The additional funds increased the CHEF budget by $3 Million and increased the CHEF program from $12 million to $15 million; approximately $2 Million was used to fund new tribes. The balance of the increase was shared with the Area Title I and Title III tribes, as well as with the Area IHS programs to provide more needed health care. Health care issues such as equity funding, health disparities as well as deferrals and denials, large cost increases associated with professional contracts, and dental are now beginning to be addressed. The CHS program continues to support the provision of care in IHS and tribally operated facilities, as specialty clinics, orthopedics, neurology and referrals for specialty services.

In addition, IHS patients are able to receive more health care services than the amount of CHS expenditures indicate. This is accomplished through a variety of mechanisms such as maximizing alternate resource requirements,

and continuing to pursue provider discounts/contracts. Alternate resource (AR) means other third party payers must pay before the IHS will pay. To accomplish this patients are required to inform the Service what type of AR they have and must apply if they are potentially eligible for an AR. Examples of an AR include private insurance, Medicare, and Medicaid.

Provider discounts/contracts are agreements to reimburse health care providers at an amount below billed charges. Types of provider reimbursement contracts at a discount include, payment using Medicare methodology, a percent of Medicare methodology, per diem rates, and percent of billed charges (if less than Medicare).

Because of the procedures described above, the CHS program has been able to purchase health care services that total more than twice the amount of the CHS expenditures. The actual amount of billed charges purchased through these arrangements cannot be completely documented because the IHS only has records for payments actually made. For example, payments by Medicaid are considered payment in full in accordance with Federal regulation. Therefore, when a patient is eligible for Medicaid and Medicaid pays the bill, there are no charges to be paid by the Service or the patient.

The IHS will continue to use the FI to process and pay CHS claims for approximately 50 percent of the CHS budget and recommend its use to tribes. The FI does maximize our ability to process claims and utilize alternate resources.

PERFORMANCE PLAN

The CHS performance indicator is based on the IHS FY 2002 Annual Performance Plan. This indicator represents some of the more significant health problems affecting AI/AN. At the FY 2002 funding level, IHS will be able to accomplish the following:

> Indicator 38: During the FY 2002 reporting period, the IHS will have improved the level of Contract Health Service (CHS) procurement of inpatient and outpatient hospital services for routinely used providers under contracts or rate quote agreements to at least 82 percent at the IHS-wide reporting level.

Following are the funding levels for the last 5 fiscal years:

Year	Funding	FTE	
1997	$368,325,000	15	
1998	$373,375,000	2	
1999	$385,801,000	0	
2000	$406,756,000	0	
2001	$445,773,000	0	Enacted

RATIONALE FOR BUDGET REQUEST

Total Request -- The request of $445,776,000 is an increase of $3,000 over the FY 2001 enacted level of $445,773,000. The increase is as follows:

Built-in Increases: +$3,000

The request of $3,000 will be shared with Title I and Title III tribes, as well as Federal programs to the most extent possible.

It is extremely critical that the IHS maintains the FY 2001 level of service to provide access and continuity of care in primary health. Maintaining the current I/T/U health system is necessary in eliminating disparities in health status between AI/ANs and the rest of the U.S. population.